# The Canadian Nurse

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## RADIOTHERAPY

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The subject that has been selected for discussion is radiotherapy, its uses, methods of administration, and effects following the use of radium and X-rays. To cover it even briefly would be to touch upon every chapter in the very large subject of radiotherapy; one can but skim the surface, dwelling briefly on the more prominent features.

### *Radium*

Radium is a metal of high atomic weight. That means it has a complex atomic structure — so complex that the intricate intra-atomic forces are not in permanent balance and tend to break down at a constant rate. In doing so the element releases three types of rays—the alpha, beta and gamma rays. The alpha rays have very little penetrating power and do not concern us; the beta and gamma rays, but especially the gamma, are used in giving treatments.

This process of breakdown of radium is very slow. It requires 1,690 years for half of any given quantity to change into the next member of the series in its gradual mutation into the final state, which is lead. Because this changing of radium to lead is so slow it is not necessary to take it into account in a lifetime of use. True enough, the aproximately six grams of element we are using at present in our department will be a little less in another twenty-five years, but it would take a physicist with delicate instruments to detect the loss. This may be illustrated by supposing that in twenty-five years we are using our present radium applicators; by then sixty minutes and thirty-six seconds will be required to administer the amount of treatment that is given now in one hour. This process of changing slowly to lead and giving out useful rays goes on incessantly, day and night, and regardless of whether the radium is in ice, or heated till the needles are red-hot. Nothing that we can do will influence the rate of breakdown nor the emission of rays.

### *X-Rays*

Now let us consider X-rays, the use of which is also included under the term radiotherapy. Nearly everyone has heard how Professor Wilhelm Conrad Roentgen discovered this ray on November 8, 1895. He was passing an electric current through a glass tube wrapped in black paper, and from which air was partially exhausted. In the dark room near him was a fluorescent screen. He noted that when the tube was excited the screen glowed like the luminous dial of a watch; he very easily traced the source of the fluorescence to the tu[illegible] beginning have [illegible] types of X-ray tubes, [illegible] have almost unbelievable cap[illegible] penetrating power. This newly-disco[illegible]ed radiation which rightfully bears h[illegible] name, Roentgen, is modestly called the X-ray.

A lecture in the series of advanced medicine given to the students in the graduating classes of the Schools of Nursing of the Toronto General Hospital, the Hospital for Sick Children and the Wellesley Hospital.

It is with regret that we learn that the story of the key in the book, lying on a photographic plate in Roentgen's laboratory is a fable. Nothing could have been more appropriate than that the first X-ray should have been a key, for that prophetic shadow would then have initiated the developments that have unlocked many of the doors formerly closed, both in diagnosis and in treatment.

### *The Difference*

The first question that arises is "What is the difference between X-rays and radium rays used in treatment?" The answer is that it is one of wave-length. The X-rays are the red and the gamma rays of radium the violet, as it were, for physics has taught us that the difference between two colours is that the wave-lengths are different. If we take the analogy from sound, the X-rays are the bass and the radium rays the treble. As one uses stronger electrical equipment and raises the kilovoltage the X-rays produced approach those of radium. With X-ray apparatus operating in the neighbourhood of a million volts, X-rays of the nature of radium rays would be produced.

The next question that one asks is if it makes any difference whether one uses X-rays or radium in treating disease. In a general way, the answer is "No, it is a matter of convenience and ease of applying it." But like most generalizations, this statement is not strictly true. To draw an anology from light again, we will say we are returning home late on a dark night, and cannot find the keyhole because of darkness. We have two flashlights, one with a red and the other with a green lens. Either could be used to illuminate the door; the colour, that is, the wave-length, does not matter for our eyes can see objects illuminated by either colour.

Now let us illustrate what is meant by saying it is a matter of convenience. To draw an analogy again, let us remind ourselves that we could use two sources of light as we stand before the door — our flashlight or the automobile headlights. It is far more convenient to use a flashlight and concentrate on a small area about the keyhole than direct the headlights to flood the whole side of the building, including the door. Also, the flashlight, held close to the keyhole, gives a much more intense and useful illumination where it is required than the flooding light from the automobile headlamps. But this does not mean that the latter are of no use, nor that they do not have their place. In the country they flood the road and adjacent fields to a satisfactory degree where a flashlight would be hopelessly inadequate. Yet many motorists carry flashlights to use when the occasions arise.

So in attempting to answer the question "Is radium or X-ray of the more use, and which is the more important?" we have tried to show that both are equally important and one is the complement of the other. It is the type of lesion, and the location of it in the patient that decide whether one or the other, or both, should be used.

### *Biological Effect*

In order to understand the uses of X-rays and radium, one must understand a little about the biological effect of the rays. The one important fact to appreciate is that they do not affect all living cells to the same degree. Young cells are more sensitive than older ones, that is, they are more easily killed. This is the principle on which radiotherapy is based. Consider for a moment and we shall see why this is true. A cancerous growth is one in which a group of cells have set up housekeeping for themselves, and are multiplying and running riot to the detriment of the host. In other words, the cells that are doing the damage are young, frequently-dividing cells. They are the radical members, the "Eat, drink and be merry," the "Here's to a fast life and a short one" element, among the more staid, slow-moving, older, more mature cells of

the unfortunate individual who harbours them. So when one has at his disposal a means of injuring and killing these young, immature cells to a greater degree than the surrounding, older, mature ones, that means should be of use in destroying the cancer without actually killing the normal cells. Radium and X-rays do this, so the rationale of their use becomes apparent.

But we must not think that these rays will kill malignant cells without having any effect on the normal tissue; it is only that they have a more lethal effect on the cancer ones. In order to kill all the cells of a tumour, it is usually necessary to give a sufficient dose to cause a reaction in the surrounding tissues. So we find reddening and browning of the skin, even blistering sometimes, and the accompanying systemic symptoms of anorexia, nausea and even vomiting. There is also a great difference in sensitivity to radiation among the different types of malignant cells. The dose that will eradicate one type of growth only slightly diminishes another type of tumour. But there is no need to go into this subject further; suffice it to say that, fortunately, malignant cells usually are easier to kill than the surrounding normal tissues.

### *Therapeutic Effects*

In dealing with the lesions treated by X-rays and radium, for the purpose of simplicity, they will be divided into (1) benign conditions; (2) malignant conditions. These in turn will be subdivided into those treated for cure, for prophylaxis, and for palliation.

Prominent among the benign group are warts, both the verrucae vulgaris found on the hands of so many persons, and the plantar warts so often in error called "corns." These are treated with quite light doses of radium or X-rays. After two or three weeks, a line of serum forms and the lesion can be cut off like the top of a water blister, or drops off itself. It is not difficult to explain the processes at work. The rays cause the death of the proliferating or growing layer — that is, the young cells — and the reaction in the surrounding tissue supplies the serum to form the little blister. Thick, horny calluses and also true corns sometimes are treated in the same way, but as there is no true proliferating layer they do not respond in such a satisfactory manner.

Some other infections are treated successfully by radiotherapy. The simple boil, the more serious carbuncle, and the disabling furunculosis that sometimes occurs in the axilla or external auditory canal all sometimes respond in a spectacular manner. This is especially true if treated in an early stage, before they "come to a head," as we commonly say. Then the boil or abscess may be aborted. Even the chronic conditions, as acne on the face or shoulders, or infections about the finger nails, the so-called paronychia, respond in a satisfactory manner to the proper dose of rays. Of all the chronic infections that plague mankind, no one was harder to treat adequately than actinomycosis. It is difficult or impossible to control it either by surgery or medicine, when once it establishes itself in the tissues. Under radiotherapy it responds in a very satisfactory manner in most cases. Now it is becoming accepted generally that the treatment of this disease is almost entirely by means of radium and X-rays.

### *Radiotherapy in Cancer*

Let us now turn to the malignant conditions — cancer — treated by radiotherapy. First will be considered the ones we expect to cure. Because a cure usually depends on getting the case early it is easily understood that these will be patients in whom the disease has attacked visible or exposed portions of the body, as skin, lips, tongue or interior of mouth. Hence it is detected early by the patient himself, his family or his friends. Then, add to these cancer of the uterus, espe-

cially the cervix — for here the onset of non-menstrual bleeding early warns the patient that all is not well. In all these cases we can offer an excellent prognosis.

In treating these cancers, radium usually is used. The reason is that radium is the more convenient and is easier to apply. It can be used in the form of a surface application laid directly on the lesion, or as needles inserted into and about the growth. Thus we locally treat the disease, and very little surrounding normal tissue. It is a concentrated attack. In other words, we are using a flashlight to centre intensively on a definite spot, and not a searchlight, to flood the whole landscape. But we must not forget that X-rays also can be used, and are being used successfully in clinics when sufficient radium is not readily available.

The actual method of using the radium need not delay us long. In most skin cancers one lays the needles directly on a sheet of lead in which a hole has been cut the shape of the lesion, and a little larger, so as to include a small rim of healthy tissue surrounding the cancer. The lead acts as a shield and only the perforated portion lets the rays through. Lesions on the lip are treated in a similar manner if they are early. If more advanced, needles are planted in the substance of the lip deep to the disease. In the tongue and mouth, needles are used and are stitched in, to hold them in place. In cancers of the cervix uteri the radium is placed in one of the several types of applicators. Usually some type of a tube passes up into the cervical canal to radiate this portion, and more radium is placed in the vault of the vagina to crossfire the exposed cervix and adjacent tissue. The advantage of using radium in locations such as the tonsil or cervix is very apparent, where technically it is almost, if not wholly, impossible to direct a beam of X-rays. Radium on the other hand is readily applied and held in place.

Now let us turn to the use of radiotherapy as a prophylactic measure. This is carried out in the case of cancer of the breast more often than in any other part of the body. As soon as cancer is diagnosed, a surgeon does a radical amputation of the breast in the hope of removing all the cancerous tissue. Then, as soon as the incision is healed, a thorough irradiation is administered to the whole chest wall, the axilla, and supra-clavicular areas, with the intention of destroying any cancer cells that may have been left behind.

Here large areas are being treated, so the floodlight rather than the flashlight technique is used. In other words, X-rays and not radium are usually employed. Using a large cone on the X-ray equipment, one can flood as much of the surface of the body as is desired and adequately radiate it — something which would not be possible without a very large quantity of radium left in place for a long time. This is economically unsound, when it can be done by X-rays quickly and effectively. The series of treatments is repeated in two months, and again three months after the second series, in order to keep the tissues well filled with radiation for five or six months, until the greatest danger of recurrence is past.

Other areas of the body may be radiated prophylactically — the pelvis following a pelvic operation for cancer; or any group of lymph glands following treatment of cancer in an area which drains into them. An example of this would be the radiation of a neck after treatment of a cancer in the mouth, in the hope of preventing a recurrence in the cervical glands.

### *For Palliation*

This leaves for consideration the most depressing group — those poor unfortunates treated for palliation only. This class includes patients with extensive metastases in the spine and pelvis, or regional lymph glands. Here one wishes to

cover large areas, so again X-rays are used as a rule instead of radium. The manner in which pain disappears even after a single treatment is often spectacular. This alone justifies the treatment of hopeless cases, for thus they can be carried on without opiates and enjoy an almost normal life. In addition, there is the psychic value of receiving treatment so that they do not feel they are being left to die as hopeless cases. Radiotherapy also is of value in ascites due to cancer of the abdominal cavity. Often the fluid can be made apparently all to disappear and the need for continual tapping is no longer present.

### *Reactions*

So far we have been considering the useful and desired results of radiotherapy. Now let us turn to some of the effects that are not so desirable. In addition to the local reaction that always is present in an adequate treatment, general systemic reactions also may be noted. These vary from a general feeling of lassitude to general fatigue, loss of appetite, nausea, and even vomiting. The real underlying cause of this so-called radiation sickness is not definitely explained, in spite of many thories. It has been found that when the liver, spleen, or intestines are included in the field of radiation the symptoms are much more severe.

In dealing with the local reaction one cannot overemphasize its importance and the necessity of its appearance. As has been pointed out above, there is always some local reaction about a malignant lesion that has received an adequate treatment. This is often erroneously thought to be a radium or X-ray "burn" when in reality it is as necessary a part of the treatment as is the incision in a laparotomy. The reaction appears a week to ten days following the treatment. First the skin or mucous membrane becomes red, or to use a technical term, an erythema develops. If a greater dose has been administered, this goes on to blistering.

SHOWING REACTION AT ITS HEIGHT

So one sees it is analogous to sunburn. Also, like sunburn, after the reaction dies away a tanning or pigmentation remains for a considerable time.

If it is necessary to administer a very large dose the next stage after blistering or vesiculation occurs when the blisters break or are rubbed off, leaving superficial ulceration from which serum oozes. If allowed to lie there, it forms large unsightly crusts, and beneath these infection may be present, forming pus that oozes out from under the crusts. So one advises boracic compresses to keep the lesion free of crusts and carbolized vaseline following the compresses to keep the area soft. If the treatment has been applied within the mouth, frequent mouth washings are ordered. Sometimes, by design, or accident, still greater doses have been administered and the next stage of a local reaction occurs — actual necrosis or death of deeper layers of the true skin, or even the muscle layers underneath. Sc

deep ulcers result. These ulcers often are indolent and slow to heal. Also, they may be painful. So, if such an ulcer appears to be making slow progress, the period of convalescing may be shortened by exercising the ulcer and surrounding tissue, and filling in the resultant area with a skin graft from another part of the body.

Fortunately this later type of reaction is very rare. By using heavy filters on the radium applicators large doses of non-caustic rays may be administered to the tissue without causing any permanent damage. Also, the X-ray treatment machines now are so designed that they cannot be operated unless filters are in place that will cut off the soft, burning or caustic rays. In trying to understand these local reactions one may use the analogy of a hot water bottle. When properly applied it causes a reddening of the skin and gives relief of pain. But if it is too hot, or applied without a filter or covering of surrounding flannel it will cause first blistering, then finally ulceration that may extend very deeply and take months to heal.

We have tried to make the principles and methods of treatment appear as simple as possible. In practice the problems are not all as easy as one may have been led to believe, and it takes experience to decide the best method of attacking an individual case. Very often the problem is made more difficult by the tardiness of the patient in seeking medical advice. So, instead of a simple, early, uncomplicated case, we are faced with an advanced carcinoma which is rapidly becoming more than a localized condition.

One final word — and if everything else that has been presented is forgotten — remember this, for some day it may save your own life or the life of one close and dear to you. It is a phrase I have heard Dr. Richards, the director of our Institute, use in the cancer clinic time and again. I pass it on to you as the strongest line of defence against cancer that we know, "The thing you should fear most is delay."

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## A GREAT SUCCESS

The refresher course held during July at the University of British Columbia and the Vancouver General Hospital proved a great success. Registrants came from Alberta, Saskatchewan, the State of Washington and outlying areas of British Columbia besides a large number from Vancouver and its vicinity. Owing to unforeseen circumstances Mrs. Mary Marvin Wayland was not able to be with us, but her schedule of lectures was ably carried out by Miss Edith Smith, from the Stanford University Hospitals, California, who on very short notice kindly consented to help us. Dr. Edith Bryan's courses on psychology and on public health nursing, Mr. Wood's lectures on the principles of teaching, and the special lectures by Dr. Frank Turnbull, Dr. Naden and Dr. Freeze, were most sincerely appreciated. The demonstrations given by the Vancouver General Hospital staff and the student nurses were exceptionally well carried out and the value of these was keenly realized by those attending. Over two hundred registered and the daily attendance was extremely good. The proceedings began with a most enjoyable tea given by the Vancouver General Hospital and ended with a delightful "no host" picnic lunch at the Sports Pavilion in Stanley Park.

# A GOLDEN JUBILEE

The city of Brantford, Ontario, like all other Canadian cities, celebrated the Silver Jubilee in royal fashion; but in addition Brantford held yet another Jubilee celebration, and a golden one, for this year the Brantford General Hospital is fifty years young. A particularly close and happy relationship exists between this hospital and the community it serves; a special edition of *The Brantford Expositor* marked the happy occasion, and the March number of the *Journal* reference was made to the nurses who successively have served faithfully and well in the capacity of superintendent. The present superintendent, Miss E. M. McKee, has established an enviable reputation both in Canada and in the United States as an able and far-sighted administrator. She has the respect and affection of both her nursing staff and her pupils and enjoys the confidence of the medical staff and the board of directors. It is largely due to her energy, initiative and devotion that the city of Brantford has just cause to be proud of its hospital. Of Miss McKee it may truly be said that she has given actual proof (if proof be needed) that nurses can and do make excellent hospital administrators when they possess the happy combination of qualities with which she is endowed.

A group picture, taken in 1888, of the Nursing Staff of the Brantford General Hospital. The central figure is MISS MARY GRAHAM who, at that time, was superintendent.

in every column was reflected the pride of the citizens in this community enterprise. The festivities lasted for a whole week, and gave an opportunity for a reunion of the physicians, nurses, and leading men and women of the community who, through the years, have built up one of the most outstanding of the moderately large hospitals in Canada.

The school of nursing in this institution has kept pace with the rapid development of the hospital itself and in

The first duty of any hospital is to care for its patients but there are other ser-

MISS E. MURIEL MCKEE

vices which a modern community has come to expect of a well-ordered institution. It should be an educational centre, a school in the true sense, for all physicians and nurses who are associated with it. Its authorities should participate in civic health activities and should make the hospital a place of health as well as of healing.

An enterprise such as this can only be successfully carried on when it is under the direction of an enlightened board of management which has the confidence of the citizens. The value of an energetic and enthusiastic Woman's Hospital Aid cannot be overestimated. There must be an able medical staff so organized as to assure a high order of professional service. The clerical, mechanical, and domestic groups must be efficient and loyal. Above all, there must be a well disciplined and capable nursing staff. Given all these things (and Brantford has them) all you have to do is to find a Miss McKee and put her at the wheel.

## REFRESHER COURSE

The Public Health Section of the A.R.N.P.Q. have planned a series of four lectures in Nutrition.

The tentative outline is:—

(1) Fundamentals of Nutrition;
(2) Feeding the Family;
(3) Special Diets;
(4) To be announced.

This series is to be open to all nurses and social workers.

Fee $1.00—Time: October.

For further information apply to Miss B. BROOKES, 1246 Bishop St., Montreal, Convener Education Committee, Public Health Section, Association of Registered Nurses of the Province of Quebec.

# NURSING IN THE COUNTRY

L. M. HANNA, M.D.

During the depression through which we are passing, trained nurses have not been called to the country on professional duty as often as before, and are employed only in serious cases. I believe the experience of most country physicians is that, as a result, second-rate midwives have sprung up to do country work and have even opened their homes to certain cases when the patient's home environment is inadequate. In the majority of maternity cases a neighbour woman looks after the patient once a day and the husband or older daughter manages between times. In lots of cases it does the husband no harm either; I have in mind a patient who had a baby every year for six consecutive years and when it came time for the seventh birth, no woman would undertake to look after the mother and baby and the other six children, so I got a neighbour to go with me for the time being on condition that I would bring her back with me. This agreement was carried out and we left when the baby was two hours old. The husband took full charge afterwards alone, and needless to say another baby is not expected this year.

### *What Country People Say*

In a few instances, trained nurses who could not get work after completing their course and are at home doing household duties, go out on cases and take what they can get in money or supplies. I always feel relieved of anxiety when I know that a trained nurse is on the job, but a lot of country folk are not impressed when you suggest a trained nurse for several reasons. They say that you have to have a maid to look after the wants of the nurse and as a rule the house is too small and the pocketbook too empty to consider the proposition. The nurse is looked up to as a kind of goddess and the people are ashamed of their modest abode, forgetting that the nurse is much like themselves and may have come from a home like their own. They think that the patient must be exceedingly sick or else that the doctor is insulting the head of the household. Most mothers have the idea that they know best how to look after their own families and will only consent to have a trained nurse when they can keep on their feet no longer.

A nurse on her first country case finds herself badly handicapped unless she has a great deal of foresight. Nursing in the country is very different from nursing in the city with modern conveniences and a fully equipped hospital where your doctor is at your beck and call day and night. People in the country may or may not have a telephone or a car; your nearest neighbour may be a mile distant and you may be fifteen or twenty miles from the doctor in charge of the case whom you will only see once in two or three days.

### *Getting Adjusted*

In country nursing the nurse must recognize certain responsibilities which must be kept clearly and distinctly in mind at all times. First and most important from the standpoint of health is your responsibility to yourself, remembering you are usually on twenty-four hour duty. A nurse needs recreation and rest as well as food if she is going to be the cheery individual she is supposed to be. I personally instruct both the nurse and the head of the household to insist on the nurse taking a brisk walk or car ride every day in the fresh air for at least a half-hour, as it brightens and invigorates her and relieves the sickroom tension. I also recommend that her rest period be arranged to suit the nursing and household cares and that she should not be disturbed except in cases of emergency.

The nurse must remember that the reputation of her profession is at stake and, indirectly, that of the medical pro-

An address delivered during the refresher course given in April under the auspices of the Moose Jaw Graduate Nurses Association.

fession. If she is bright, cheery and thorough and radiates the confidence which both physician and patient have placed in her, she will reap a rich harvest of compliments and comfort in feeling she has done her best. Only the family physician realizes how much a nurse is appreciated. I had a nurse fourteen years ago who took several cases for me and even yet people inquire about her and, when a nurse is needed, wish she were free to come. On the other hand, I had an excellent nurse once who had worked with me for nearly two years. In this particular instance she was nursing a bank manager's wife and her new baby. Both patient and nurse were set in their ways and during the whole time they were together I was ironing out difficulties. Each expected me to side with them. At last there came a showdown and I had to take a stand which resulted in a three-cornered squabble and three good friends parted, and a capable nurse was forced to leave the district. In nursing you will find that we are all a little peculiar along certain lines but we must learn to give and take because we are public servants, depending on others for our living.

***Doctor and Nurse***

In country nursing a nurse is thrown more on her own resources than in city or hospital nursing. It is important that after reviewing the case, that the physician and nurse take one another into confidence and discuss the symptoms and treatment pro and con until the nurse is fully conversant with them. To do this successfully, the nurse must have confidence in herself and in the physician and a complete understanding of what may be expected. The physician can probably only visit the patient every couple of days and has to depend entirely on the nurse's report, so you see how absolutely necessary it is to keep your case well in hand because you may have to act the part of the physician in emergencies. When such circumstances arise, go about your work as usual, without hurry or excitement for otherwise you convey these to both patient and others of the household. Get in touch with your physician as soon as you can but do not call too often. You will be surprised at how much you can do yourself if you keep cool and collected but you cannot think or act properly if you lose your head.

For example, I once had a nurse waiting on a maternity case and labor set in very rapidly. Before I could get there, a baby was born but the membranes never ruptured. Pain continued and the nurse got excited and started massaging the womb. In a minute or so, a second baby was born in the same sac which still did not rupture. The nurse went flying around grabbing this, that, and the other thing, and getting nowhere. In the meantime the babies (twins) drowned in the amniotic fluid and when I arrived a few minutes later, both were dead. If the nurse had had the presence of mind to simply break the sac and turn the babies face up and had done nothing else, everything would have been all right. The babies were monstrosities and better dead at birth than later, but both patient and nurse were in a fearful state of mind and were hard to calm down when everything was over.

***Relationship***

Very important is your responsibility to the patient whose life you hold in your hand. The first thing to do is to gain his or her confidence. Do not talk of the patient's case or of others like it. Every physician has his own way of handling cases and knows what to expect from his treatment; this should not be discussed with the patient or her household by the nurse. The less said the better for all concerned; there is always a way of diverting conversation into channels not pertaining to the case at all. You are responsible to the patient's family to whom it is sometimes hard to be civil and polite. When you think of the hard-

ships you are undergoing and how you are hampered by the old ideas of the grandmother and the neighbours it is not easy always to keep a cool exterior. Most country folks are frightened of fresh air in pneumonia and will close the window every time you open it but you can usually get your way by pretending there is a bad odor in the room, or gas from the stove or the furnace. When they see it does no harm but that the patient enjoys it, they will submit. If you are diplomatic you can make people think they are getting their own way while in reality you are doing what you know to be best. Keep in with the family if possible.

### *Things You Need*

A nurse needs acute perception. She may be well trained (and she gets a good training) in the use of modern equipment but may not be prepared to use her five senses as well as she might. I would rather have a nurse in the country who is perhaps not very proficient in handling blood transfusion equipment but who has a fair grounding in all lines of nursing and lots of good common sense. The lack of this gets both physician and nurse into a lot of difficulties and many times makes bad friends and spoils good reputations. A nurse going out on a country case should be equipped with a good hypodermic set with lots of needles and the following hypodermic tablets: morphine grs. ¼, atropine grs. 1/150, and strychnine sulphate grs. 1/60. She should also have a first-aid kit containing a good pair of scissors, a pair of plain forceps, a little absorbent cotton, a bandage or two, a small bottle of iodine, an ounce of fluid extract of ergot and a hot water bottle and connections.

### *A New Trend*

So much for private nursing in the country. The future of nursing does not, however, lie in this field but rather in hospitals and public health agencies. The modern trend is towards small municipal, Red Cross, or private hospitals and we do not have to look far into the future to see small hospitals dotted all over this country supported by government and municipal grants. The nurse in charge of these institutions should have a certain amount of training which will help her to become an efficient hospital manager, able to shoulder the responsibilities of these institutions, because both financing and nursing will be included in her work.

A nurse taking over the management of one of these small institutions has to be a good diplomat because she not only has to impress the patient with the sense of efficiency but also the public who visit the patient and institution. She will have to build around her a staff who have the good name of the hospital at heart and are not just making a living. She will have to take charge of groups of community workers and keep them interested and busy, in fact, she will be a leading light in the community. Not only the head nurse but also her subordinates must accept these responsibilities, because as a rule, there will only be two or three nurses on the staff.

Nurses, like doctors, have always been classed as poor business people, but the depression has taught most doctors to make the best of what they get and to collect as they go along as much as possible; I presume the nurses also have had to knuckle down to the unpleasant task of pressing for funds. The modern way of collecting I have found is taking supplies needed in the household as part payment on account and this way you will find most people are anxious to give.

### *Force of Example*

Here let me say a word on habits and morals because in a small community the nurse's influence is very great. Children in their play and especially girls, imitate certain people who impress the young mind. What the nurse does while on or off duty is bound to be reflected by the children of the community so that you can be a great force for good or evil.

You should belong to the best clubs and other organizations and should attend their meetings. Always keep your work before them because everybody is naturally interested in the care of the sick, and from these organizations you will derive benefit and encouragement for your institution. If after visiting a household, your conduct leaves a good impression in people's minds, it is surprising how much better a time you will be given by the people in whose community you are working.

***Public Health Aspects***

Lastly, a nurse needs some training in public health because undoubtedly the future will require a great number of well-trained public health nurses. The visiting nurse is a community asset because she has been trained to observe slight deviations from normal and to know how to correct these. She has a fund of knowledge from training and experience in the prevention of disease. She is familiar with the social forces of a community and knows the interrelations of various organizations. She is equipped to help individuals to find the organization which can give them the most help. In her professional work the service which she renders is applied directly to the individual in the home or school. Her services are acceptable to all classes of society, all ages and under all conditions. She ministers to basic human needs. Her objective always is the prevention of disease and promotion of health. This objective she shares with the health officer of her community and she is in direct competition with no profession.


# COLLEGE OF SAINT TERESA

## WINONA, MINNESOTA

### Conducted by the Sisters of Saint Francis

To meet the pressing need for more adequate professional education for nurses, the College of Saint Teresa, Winona, Minnesota, has provided an expanded full-year program to become effective in September, 1935. Sister M. Domitilla, R.N., M.S., Director of Nursing Education, Saint Mary's Hospital, Rochester, Minnesota, has been appointed head of the Department in Nursing Education. It is the aim of the College to prepare nurses for the work of administration, supervision, and teaching in schools of nursing. Although the principles of nursing school organization, the principles of nursing education, the revision of the national curriculum for schools of nursing, and issues in nursing education are major factors in the development of the course of study, the cultural and the social phases of the nurse's education are given due emphasis.

Saint Mary's School of Nursing in Rochester, Minnesota, provides demonstration, observation and opportunity for experimentation as a part of the educational program of the graduate nurse who is a college student. The school is administered and supervised by a staff whose members have proved their ability to recognize and meet the problems of nursing education. This demonstration school provides an opportunity for prospective nurse teachers and administrators to come in contact with nursing school problems and to become familiar with educational theories, principles, and policies in their application to such problems.

The College of Saint Teresa is a standard liberal arts college of the first rank. It confers the regular degrees of Bachelor of Arts, Bachelor of Science, and Bachelor of Science in Nursing. It holds membership in the North Central Association of Colleges and is accredited by the Association of American Universities. It is registered for Teacher's License by the New York Board of Regents.

# NURSE ANAESTHETISTS

MADELEINE ARENT, Anaesthetist, Lawrence Hospital, Bronxville, N.Y.

The New York State Association of Nurse Anaesthetists appreciated to the full the courtesy of our State Hospital Association in extending an invitation to meet with them, and we who live in Greater New York felt that we were most fortunate in having New York City again chosen as our convention headquarters.

Our organization is very young and the meetings held in May mark our second annual convention. But already our membership has topped that of any other state group, Pennsylvania holding second place and Ohio third. The business meeting occupied the first morning and we joined the New York State Hospital Association for luncheon when Mr. Alfred E. Smith, ex-Governor of New York State, and Mr. Robert Jolly, president of the American Hospital Association, were the principal speakers. Both were popular and convincing, and as we returned for our afternoon session one was not surprised to hear remarks such as, "I just feel that I want to go out and work with them!"

Miss Cora McKay, president of the New York State Association of Nurse Anaesthetists, delivered an address in which reference was made to the attempt that has been made in New York State to secure legislation against the nurse anaesthetist. In 1934, the bill to abolish the nurse anaesthetist in New York State, did not come out of committee, and in 1935 was not brought up at all. This accomplishment we feel was only possible through the co-operation of the New York State Hospital Association and its special committee, which has gone on record as not being favourable to the discontinuance of the services of the nurse anaesthetist. Albeit we have been warned that the pressure will continue just so long as the present economic situation exists.

Mrs. Gertrude L. Fife, president of the National Association of Nurse Anaesthetists, and director of the Post-Graduate School of Anaesthesia at the Western Reserve University, gave a paper on anaesthesia in heart surgery. Her experience in this field began in 1928 when Dr. E C. Cutler performed the delicate operation for stenosis. This was followed by the outstanding work done by Dr. C. S. Beck in Pick's disease, and covers ten pericardectomies. Nitrous oxide-oxygen-ether, the anaesthesia of choice, has been determined only after years of extensive research work on dogs. In these cases of cardiac compression there is a band of scar tissue about the heart binding it to the sternum. The patient is cyanotic, and breathing is difficult. There may be an accumulation of fluid at the base of the lung accounting for the presence of mucus in the air passages. The duration of the operation is from two and a half to three hours. It has been observed that when work on the heart is suspended the pulse improves; therefore, at stated intervals throughout the operation, the heart is allowed to rest from three to three and a half minutes. In stripping the pericardium there is danger of rupturing into the heart, but every precaution is taken to safeguard the patient. Before operation is begun everything is made ready for a blood transfusion, the donor's arm prepared, and a second surgical team ready to give the blood at a moment's notice. The moving-pictures of these cases were very complete, showing the patient on admission to hospital, a close-up of the operation, the patient during convalescence, and finally after discharge from hospital. The accompanying graphs were beautifully prepared and most instructive. Mrs. Fife answered the many questions put to her, but as this is a highly specialized branch of surgery, there were few, if any, present who were in a position to discuss this interesting paper.



Institute of Public Health
Faculty of Public Health of the
University of Western Ontario
LONDON - CANADA

Anaesthesia in obstetrics is familiar to us all and was the subject of a comprehensive paper given by Miss Martha Hennenberger, anaesthetist to the Woman's Hospital, New York City. We liked Miss Hennenberger's tribute to the great Dr. J. Marion Sims, the founder of the Woman's Hospital, and appreciated the inclusion of a paragraph from the hospital report of 1915, in which it was recorded that the anaesthetic service had been much improved due to the appointment of two full-time nurse anaesthetists. Twenty years ago this great hospital rejoiced in the fact that the nurse anaesthetist "lived in" and was therefore available at all times!

During the year 1934 there were one thousand four hundred and eighty-four obstetrical anaesthetics administered at the Woman's Hospital. This large number includes every combination that one can think of. Nitrous-oxide-oxygen, nitrous-oxide-oxygen-ether, chloroform-ether, avertin, rectal ether, paraldehyde, pantopon, scopolamin, sodium amytal, and pentobarbital sodium. The popularity of avertin as a basal anaesthetic is increasing daily, but in obstetrical analgesia it does not seem to give the satisfaction that we have come to look for in some of the older techniques. Today at this hospital the most satisfactory results are obtained from the use of pentobarbital sodium and scopolamin.

A whole morning was devoted to clinics at Bellevue Hospital, Long Island College Hospital, Brooklyn Hospital, and the Hospital for Joint Diseases. At Bellevue Hospital we were interested to note that the Foregger metric gas machine was the one most generally used, in combination with the soda lime filter, so popular in recent years. We were fortunate in seeing a beautiful cyclopropane induction, with the introduction of an intracheal tube for the administration of nitrous-oxide-oxygen-ether, for a gastro-enterostomy.

In the afternoon Mr. P. Godfrey Savage, president of the New York State Hospital Association, addressed us, giving generously of his advice and encouragement in the problems that lie before us. We have been criticized because we have formed an association, but it is only through organization that we shall be

Miss Charlotte Kuhn, anaesthetist, Crown Heights Hospital, Brooklyn, covered the subject of spinal anaesthesia. Miss Kuhn spoke with authority (having been the subject of a spinal anaesthetic herself) for during the past seven years it has been her privilege to administer one thousand spinal anaesthesias, and to have observed seven thousand. Miss Elizabeth Flint, anaesthetist, Neurological Institute, New York City, spoke with the utmost modesty and simplicity of the work that she has been doing in one of the most difficult fields of anaesthesia over a period of fifteen years. An enviable record indeed. No anaesthetic programme would be complete without a message from Dr. Ben Morgan, so it was with genuine pleasure that we welcomed him to our gathering, later going to see a demonstration of the latest Ben Morgan anaesthetic machine.

# THE EDITOR'S DESK

***Readers' Guide***

There is a good deal of uncertainty as to how much or how little instruction should be given to nurses in the elements of physics and chemistry. In his article on radiotherapy Dr. Irvine gives a remarkable illustration of the practical application of such knowledge in the nursing care of patients who otherwise might be exposed to grave risks. And if you are specially interested in teaching methods just examine this article from that standpoint also; it is a fine example of the judicious selection of essentials as well as a model of clarity and simplicity of expression. Draw this to the attention of the physicians who share in the teaching programme of your school. This is the sort of thing we want from them instead of a highly technical treatment of the subject from a medical rather than from a nursing angle. A supplementary article, written by a nurse, and dealing more specifically with nursing techniques in radiotherapy will appear shortly. The two articles should be studied in relation to one another. △ In "Nursing in the Country" Dr. Hanna, who knows whereof he speaks, has given us some straight from the shoulder advice which we would do well to heed. Indeed he has done much more than that: he tells us not only what nursing in the country now is, but what it may become if we rise to the occasion. △ The vexed question of the legal status of the nurse anaesthetist is agitating more than one Canadian province at the moment. Miss Madeleine Arent, who is herself a registered nurse as well as a qualified anaesthetist, gives us a glimpse of the interesting proceedings at the recent convention of the Association of Nurse Anaesthetists which has been formed in the United States as a means of mutual protection. △ Miss Gertrude Bennett, director of the School of Nursing of the Ottawa Civic Hospital made a valuable and thoughtful contribution to the symposium on the Victorian Order of Nurses and its relationships which was one of the features of its annual meeting. The reaction of student nurses to the experience afforded them by arrangement with the Order is specially worth noting. △ This month Miss May Jones makes a strong plea for the eight-hour plan for private duty nursing. In her opinion, it is useless to compromise: all must subscribe to it if it is to be a success. We have a leaning towards compromise, but we are open to conviction. Comments will be welcomed and will appear under the caption of "What do you think about it?" △ Are you following the Trail of Adventure? It takes an unexpected turn this month. △ By way of shaking off summer sloth and bringing yourself up to date, be sure to read *Notes from the National Office*. The Provincial Associations are certainly up and doing.

***A Bereavement***

Nursing education in Canada has lost staunch friends and wise counsellors in the tragic deaths of Mr. and Mrs. Reginald Brock as the result of an aeroplane accident. When it was first organized in the University of British Columbia in 1919, the new Department of Nursing and Health was attached to the Faculty of Applied Science and, through the years, Dean Brock consistently supported and defended it. When the experiment met with strong opposition, he refused to be shaken, and as it slowly came to justify his faith in it, he did all that he could to foster its steady growth. Mrs. Brock took a personal interest in the students, both graduate and undergraduate, and year after year extended her gracious hospitality to them. To the countless tributes already paid them the nurses of Canada will wish to add theirs. *They were lovely and pleasant in their lives and in their deaths they were not divided.*

# ON THE TRAIL OF ADVENTURE

Arabia, June, 1915.

Dear E.,

Who says Aden is unattractive! It's the most fascinating spot on the globe. After the first woolly week when the universe seemed full of strange smells and the wildest looking Bedouins attached to strings of camels, I got my bearings a bit and now revel in everything. The bungalow with its high rooms and wide verandahs is a joy, and I look straight over the desert to the barren rocks of Aden and the bluest of seas. At sunset it is a fairyland world, for all the colours ever invented seem to get spilled over things with a lavish hand and the soberest camel is transformed. And such nights! With a big yellow moon rising over the edge of the desert and a string of camels silhouetted against it as they slowly wend their way into the mysterious hinterland. And other nights, like black velvet, with no moon but the most amazing stars. It's pure joy to sleep under them on the open verandah.

At 6.30 a.m. after *chota hazri* comes Ali Hageri with his English victoria and a most superior camel, and this surprising combination conveys me to the hospital. Our way lies partly through the village which smells mysteriously of wood smoke and all the "perfumes of Araby", and tinkles musically with the bracelets and anklets of the women as they flit about with flashes of brilliant garments under the long black *shadirs*. The children crowd on to the *ghari* and we arrive at hospital *en masse*. Then follow some hectic moments while the camel returns for the doctors, and with their arrival the day starts in earnest. Twice a week we have field days of operating, sometimes from 7 a.m. till 6 p.m., the two doctors hard at it, with myself, the one nurse, a sort of pendulum between them. Salem administers anaesthetics and Abdulla, Nagai, Cassim and others find many and varied jobs. There is a lull for tiffin served on the verandah by one of our "boys" after which we go to it again. When the monsoon blows dust over everything and temperature soars, I have thought longingly of a Labrador blizzard, but even the worst day gets over somehow.

Mission hospitals have to be elastic and this one is no exception. Our patients come many days' journey to us, from hundreds of miles over the desert and we would die rather than turn a real case away. So they overflow cheerfully into the compound where private patients are housed in what look like commodious bathing boxes, and lepers live together under the trees, and except in a dust storm I think the lepers score as regards accommodation. It is a wonderful sight to see all the different types and the interested faces while the doctor takes morning prayers, always the beginning of each day.

And then there are outside excursions. The other day the doctor was called to L., sixteen miles across the desert, to see the Sultan's wife, and to my joy he decided a nurse was indicated. Our hospital is one of the "outposts of the British Empire" and beyond our village no one ventures without special permits and escorts. The doctors have permanent passes so we set out gaily in a hefty motor car belonging to His Highness, with a camel escort. At intervals we stuck fast in the sand and camels hauled us out, the escort meanwhile dealing out instructions and commands freely. Arrived at the palace, we were regaled with syrupy tea while a telephone message acquainted the harem of our presence. Then we were led through endless passages, up and down narrow staircases and through rooms to the women's quarters where the patient awaited us. The doctor was only allowed to see her and her slaves, but I was much in demand by the other ladies who questioned me at length and chattered vigorously amongst themselves, but my limited knowledge of Arabic cramped my style badly. We were finally escorted home with many thanks and a generous fee for the hospital treasury.

Sunday is varied by an evening drive into T. and the service in the little church. Then we come home sometimes in brilliant moonlight—sometimes with the wonderful stars—to supper, and so to bed.

Yours ever,

L.

P.S.—I must mention our royal invasion. Three minor sultans from the hinterland suddenly materialized, suites and all complete, on the tennis court and demanded "dowa", i.e., medicine. They had been into Aden and were returning to their country armed to the teeth to defend various passes from the Turks, who, we hear, lurk up country ready to pounce.

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S.S. *Matiana*,
Steamer Point, Aden,
July, 1915.

Dear E.,

I am almost too breathless to write. We are refugees and our hospital and bungalows are in the hands of the Turks. Don't I give you exciting news!

I was on my way into Tawahi to spend a night with the wife of one of the officers in the native regiment, and *en route* we passed

the British Regiment marching out to defend Lahey. My hostess and I spent the night on the roof of her bungalow while her husband appeared at intervals from the "front" with items of news. Apparently the three sultans had been unsuccessful in their defence of the passes and the Turks had got through and were making for Aden. Next day was Sunday. The doctor telephoned that his bungalow was full of sun-struck soldiers. While we were at service in the little church in the evening we heard continuous firing, and directly the service was over Dr. Y. and I dashed out to Shak in the car. The Turks were then at L. I managed to rescue some things belonging to the nurse on furlough and threw a few of my own possessions into a trunk and these were taken into Aden on a military lorry. Then we worked hard most of the night, though the doctors insisted on my lying down part of the time. On Monday Dr. Y. was commandeered to act as Port Health Officer. Our troops were ordered to retire, leaving S. to the enemy as we had not enough men to defend the place. We simply flew round packing up hospital stores, sending some patients to their homes and taking the worst cases into the Civil Hospital in Aden in the old car. That night we spent in T., and dashed back to collect more goods, the hospital being then empty of patients. In the midst of our activities the army departed, taking the police force with them. At once looting and burning began, and our hospital boys, armed with amputating knives, departed in haste to defend their homes, and implored us to sneak off by back ways. This didn't appeal to either of us so we motored through the village quite safely and came through our own firing line to their intense astonishment.

In the club a cable awaited me from my Frontiersmen ordering me to E. Africa. I nearly went off on a French steamer, but waited for a British India one which was expected next day. She came in on Sunday. I went driving in a *ghari* with the doctor to say good-bye to friends. We got engaged! went to the evening service and about 11 p.m. he brought me on board as we were to sail at dawn today.

At 6 a.m., we being still here, he came out to find the ship's doctor had died of heat-stroke. Being out of a job, he dashed ashore and got signed on as ship's doctor to Mombasa and back here. We mean to be married by the Bishop of Mombasa who came out from England with us and seems an old friend; then I'll go on to Nairobi to my regiment and be able to join A. whenever possible and wherever he is.

So do you wonder I'm breathless? I've scribbled notes to the family and we are on the point of sailing so this must go ashore.

Yours as ever,
L.

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Mombasa,
East Africa,
July, 1915.

Dear E.,

Our wedding day, and I'm "woo'ed and married and a'" in the space of ten days. We stayed a week with the Bishop and his nice daughter while the Governor, who happened to be in Mombasa, sent to Nairobi for his special licence book. An American and his wife came here with us to avoid the local scrimmage and he gave me away. A. and I went shopping and got the last wedding ring in Mombasa, and after much trouble I found a strange gauzy material to act as a veil. A topi seemed inappropriate as headgear for a wedding.

And today it all happened! I ironed an old white dress; Miss P. draped a scarf over it and the veil and real orange blossom were pinned on, and with a really magnificent bouquet from the garden Mr. S. and I walked through the compound to the white coral cathedral. We were too early and had to shoo the congregation of ship's officers into the church in front of us. Miss P. played the organ. A. was waiting for me; Mr. S. "gave this woman" and two refugees suddenly belonged to each other. Then we drove in a car crowded with guests and rice to the hotel nearby where we ate and drank something and there were speeches.

Now I'm dashing this off before catching the train to Nairobi. My husband is coming to hand me over and we have been together so much there seems nothing new or strange, only my wedding ring feels very heavy.

The nice best man has sent cables home and I long to be on hand to see how you all react.

Yours—as always,
L.

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Voi,
East Africa,
July, 1915.

Dear E.,

My journeys seem fated to be eventful. We were peacefully asleep last night when the train stopped nowhere in particular and we overheard a spirited conversation between the G.O.C. in the next carriage and his A.D.C. Apparently news had come through, from a man called Wavell, that some Ger-

mans had been seen near the railway line, and the A.D.C. was all for caution and a scouting party of King's African Rifles. The G.O.C. wasn't keen on any delay, but at this point the engine driver chipped in. He had been bombed once and didn't like it, and didn't intend it to happen again. So we waited, and after a bit word came that the line was bombed five miles ahead. Then things fairly hummed. I, being the only woman on the train, was exempt, but the men were all armed and we spent a watchful night ready for man or beast. Early today we were provided with armoured cars and a strong guard and have reached this spot where we are to remain till morning. Our honeymoon journey seems likely to be prolonged, and as it is all I expect of a honeymoon we are cheerfully resigned.

The scenery is vastly intriguing; great areas of low scrub with natives in complete undress strung along the railway line, and giraffes, deer of sorts, and other strange fauna in the offing. It's the country for lion, but I'm not hankering for a sight of one. A. and I are covered with red dust, but so is everyone else; and the tea is mostly sand, but who cares?

A train is likely to pass which will take this back to Mombasa—so here's luck.

L.

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Nairobi,
East Africa,
August, 1915.

Dear E.,

Life is certainly unexpected. When we finally reached here a jeering crowd from the hospital awaited us. Their first nurse had got married, the second was engaged, and here was I, married too! But a fourth was all agog for the job, as her husband is in the regiment. So to my exceeding great content I am free to go back to Aden with A. and have a hand in what awaits us there. Meanwhile we are spending a delectable few days with the Treasurer of the Colony and his charming wife. We have been to the outskirts of the town where the men played golf and we heard hyenas; have driven in rickshaws, horses being unknown here because of the tsetse fly; and have generally sampled much hospitality and kindness. Tomorrow we return to Mombasa to rejoin the *Matiana* and this time will stay in the hotel—Bishop's Court being full up.

In haste,

L.

[*Editor's Note*: These letters were written to a friend by Louie Brice (now Mrs. Alex. MacRae), a graduate of the class of 1912 of the School of Nursing of the Hospital for Sick Children, Toronto. Mrs. MacRae now lives in Newcastle-on-Tyne, England, and with her kind permission as well as that of Miss P. B. Austin, superintendent of nurses, the Hospital for Sick Children, the *Journal* is privileged to publish this delightful record of adventures in many lands. More letters will appear in successive issues.]

# Department of Public Health Nursing

## A TIMELY WARNING

A leaflet giving a clear description, in simple and popular language, of the symptoms of poliomyelitis has been prepared and is being distributed by the Canadian Welfare Council. Public health nurses will find this useful for distribution during the coming months and copies may be obtained through the respective Provincial Officers of Health. As a precautionary measure it is well for all nurses to recall the obscure symptoms which may be the only warning of the onset of this insidious disease. The following synopsis is quoted from the leaflet mentioned above:

Poliomyelitis is most prevalent during the months of August, September and October. A considerable number of cases occur in July and November, and occasionally cases crop up in the months of May and June, and not infrequently in the winter months. Canada is visited by this disease each year. The greatest number of cases in recent years occurred in 1930 and 1931, when there were 1,030 and 1,341 cases respectively. In 1928 there were 728; in 1929, 753; in 1932, 956; and 246 in 1933. The mortality is extremely high and from 1927 to 1933 there was an average of over two hundred deaths per year. The number of children crippled as a result of this disease is not known for the whole Dominion, but there must be a great many. The high mortality, taken in conjunction with the unsightly and handicapping crippling of many of the survivors, puts this disease in a class by itself as a treacherous illness — a depredator of young lives and limbs.

It would appear that convalescent serum, when administered in the early stages of the disease — in the so-called pre-paralytic stage — sometimes prevents the development of the paralysis and lessens the mortality; but, certainly no benefit can be expected from the use of serum unless the doctor is called on the appearance of the earliest symptoms. If parents are forewarned and equipped with some knowledge of how their child is likely to react to this infection, much suffering and future crippling of their children may be avoided.

### *Symptoms*

These cannot be said to be constant or regular in their appearance — even the physician may be puzzled or misled by the earliest symptoms. There may be a vague sort of illness, especially in the early stages, and many of the symptoms may be lacking later on; but, if one or more are present, take no chances but hasten at once to procure a doctor. Usually, the onset is sudden with fever. The child may be flushed and thirsty; he may appear to have a head cold, or he may complain of a sore throat. There may be a cough, or he may vomit or have diarrhoea. Quite likely he will lose his appetite. He may be drowsy, peevish, irritable or, on the other hand, he may be restless, wide awake and very bright mentally. If drowsy, he is usually alert if awakened and an anxious, frightened look is not uncommon. He may not urinate, and may sweat a good deal. His neck or his back may be stiff, and he may complain of this stiffness; he may complain of frontal headache. His body may be tender to touch, especially the legs, and he resents handling. Sleep may be disturbed by twitching, and his hands may shake and tremble; his eyes may be sensitive to light.

A child may have fever and some of the above symptoms for a couple of days and then appear to be much better for from one to four days, followed by the onset of more serious symptoms, and later paralysis. Parents should not be lulled

into a false sense of security by this so-called latent period.

Since a great many of these symptoms may be present when a child has an attack of influenza, or an acute intestinal upset, one must also be on the lookout for the following important signs, which do not occur in these conditions:

*Spinal stiffness*: The head may be bent on the neck but efforts to bend the neck on the shoulders cause pain and are resisted.

*The knee-kissing sign*: The child is unable, while sitting up in bed, to bend his head down and kiss the knees. It hurts too much.

*Head dropping*: When a child is raised at the shoulders, the head tends to drop backwards.

*Peculiar attitude*: When he sits up, he props himself behind with the extended arms supporting a tender or painful spine.

*Rapid pulse*: This symptom is always present.

If the doctor is to be of any assistance, he must be called as soon as the slightest suspicion is aroused, certainly within twenty-four hours of the onset — the sooner the better. He may desire to perform a lumbar puncture, for in this way an early diagnosis can be arrived at and any necessary treatment instituted. In the months of June, July, August, September, October and November, parents should be constantly on the lookout for this condition particularly if there are any cases of infantile paralysis in the community, but remember that sporadic or isolated cases may and do frequently occur.

Infantile paralysis is infectious for about twenty-one days. Be sure to keep any child with suspicious symptoms in bed, and isolated from other children, just as you would isolate or quarantine a case of scarlet fever. The infection is thought to be present in the secretions of the nose and the mouth.

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## A RESPONSE TO CRITICISM

**EVELYN MALLORY, School of Nursing, the Vancouver General Hospital.**

We hear a good many complaints (from our good friends the public health people particularly) of the neglect of health teaching by those doing hospital nursing. Here is one answer — an excerpt from a case study by a junior nurse who has not yet completed her first year. It might interest those who believe that in hospitals we do only "sick nursing."

"Mr. C. gave me a grand opportunity for health teaching. The first night that I gave him evening care I asked him if he had a tooth brush. He said that he never had one in his life but had only used chewing gum and soda (chewing gum particularly is bad for the digestion and would only aggravate the pyloric ulcer). His teeth, as a matter of fact, were in fair condition but not a very good colour. I obtained a tooth brush for him and he was very much taken with it and was most particular that he got his mouth wash morning and evening even though he was allowed up to the bathroom. Apparently when his children visited him (he had seven) he showed it to them with pride and they were so delighted that he asked me to buy two or three more for them — and again several days later four more for the rest of the family. So now I am happy to think that the C. family are well supplied with gay tooth brushes through the good offices of the Vancouver General Hospital, and that the children now have a chance of good healthy teeth."

# Department of Private Duty Nursing

## WHERE DO WE STAND?

MAY JONES, Private Duty Nurse, London, Ontario.

The length of the working day of the private duty nurse is a highly controversial question at the present time. There are hospitals in our province which are permitting twenty-four-hour duty even in this enlightened age, and it appears that nurses may continue to do twenty-hour duty unless they take the initiative and refuse to be slaves to such a custom. It seems a far cry from twenty-hour duty to eight-hour duty and yet we firmly believe the time is ripe to force an eight-hour day for private duty nurses in hospitals. Last year at the provincial convention in Toronto, only two centres reported any definite steps toward establishing an eight-hour service. We are anxious to hear how many other centres have established such a service this past year. In one instance at least it has been a conspicuous success, and I have permission to quote the following letter from Sister M. Dorothea of the General Hospital, Sault Ste. Marie, Ontario.

I am pleased to give information about the eight-hour system which has been carried out here for over two years, and has proved most satisfactory. When the Graduate Nurses Association planned this move they asked our co-operation. We readily consented and the change took place without the slightest inconvenience to patient, hospital or nurse. From the hospital standpoint there is really nothing to gain, neither is there much to lose. The going and coming of the nurse does not in any way affect the general routine of the hospital. Sometimes we find that a patient having two nurses expects the same unremitting attention from the floor nurse as from her specials, and this makes it rather difficult for the floor supervisor at times. The hours of duty (with three nurses), are 7 a.m. to 3 p.m., 3 p.m. to 11 p.m., 11 p.m. to 7 a.m., but the hospital calls on a nurse at any hour. Each nurse is paid $3.00 for eight-hour service. The patient really benefits most by this change; she may employ one, two or three nurses, and should she need three, the cost to her is less than two under the old system. If she wishes but one, we have her at night from 10 p.m. to 6 a.m., and if she desires two, we have one for the night and the other at the time most suited to the needs of the patient. Incidentally we try to arrange that the nurse will be on duty at the time that the floor nurses are busiest. I may add that there has never been the slightest friction in the arrangement of the hours. We try to please the sick in the selection of a nurse and as only the critically ill can afford the luxury of three or even two nurses, we have no difficulty in meeting the demands. The advantages to the nurse are obvious. It gives employment to a greater number, it gives them sixteen hours away from the bedside of the sick; they come back more rested, more refreshed and more active; they have more time for home life and social obligations and I believe it keeps them more together.

### *No Exceptions*

From our experience in London we have learned that to try to establish an eight-hour service in addition to the existing twelve-hour service is a mistake. Apparently the only successful way is to establish a straight eight-hour duty service and give no choice of any other service. How can this be done? Naturally we would expect some opposition from the laity but once a rule is established the opposition is soon overcome *providing no exceptions are made.* If we wait until the medical profession, as a whole, approves or supports eight-hour duty, we shall wait for another century or so, for many of them still expect a private duty nurse to do twenty or twenty-four-hour service. As for governing boards of hospitals, and unfortunately even some superintendents of schools of nursing, they do not approve of private duty nurses establishing eight-hour duty in hospitals and claim that if a patient desires a twelve-hour duty nurse they (the hospital administration) have no right to refuse it. So, it appears, the

private duty group can expect little or no support from these authorities. Therefore the task of inaugurating eight-hour duty is ours, and rightly so, for it is our problem and not that of hospital superintendents, or governing boards. It can be done, but only in one way: by the support, loyalty and co-operation of *every* private duty nurse practising in the community. Even a very few nurses who prefer to continue doing twelve or twenty-hour duty, when the majority favour eight-hour duty, can ruin any attempt to establish an eight-hour service.

### *Why We Want It*

We believe eight-hour duty is threefold in its advantages: first, it gives a less expensive nursing service to the public; second, it makes for more even distribution of work among the nurses; and third, it creates more work for the private duty group. The question of fees is important here. From Vancouver comes the advice that the charge for eight-hour duty should not be less than $3.50 but not more than $4.00, and that anything over eight hours be charged at the rate of fifty cents per hour. Perhaps we valued our services too cheaply when some of us set the fee at $3.00, and yet there are hundreds of well-trained and efficient registered nurses who would gladly accept this fee and thousands of sick individuals who cannot pay more.

I am sure that if every registered nurse in Ontario who is practising her profession as a private duty nurse were permitted to work eight hours per day, at $3.00 per day, for eleven months in the year, the problems of finance and economics would be solved for each individual nurse. Instead, we have a small group employed about three-quarters of the time and the remainder employed very spasmodically and averaging only short cases. No wonder so many of the private duty group are unable to provide for their later years.

Can the private duty nurse attending a very sick patient for twelve hours, then spending another two hours in transporting herself to and from and an average of one hour daily in attending to such personal matters as laundry and bathing, find time for such economies as sewing, mending and housekeeping? Can she find time for educational reading or even reading for enjoyment and relaxation? Can she enjoy social life with her family and friends or look forward to periods of recreation and sport which are necessary for a well-balanced life? You will be forced to answer "No" to these questions, for the average private duty nurse on twelve or twenty-hour duty cannot manage such activities. All that she is able to do, or is fit for at the end of the day, is to tumble into bed for six or seven hours of sleep to be aroused by her alarm clock to arise and prepare herself as best she can for another day's work. No wonder such a nurse is often spoken of as uninteresting; what time has she to acquaint herself with the topics of the day and with current affairs either in the country in which she lives of those which are of world-wide interest?

### *Opposition*

If you have discussed or are about to discuss eight-hour duty, you will find that your greatest opposition will come from a small group of private duty nurses who are employed most of the time and who, because of selfish interests, are not big enough to sacrifice personal gain for the benefit of the much larger group, many of whom are actually suffering and in need of the bare necessities of life. There are just as capable and well trained nurses among the unemployed group as there are among the employed and some day, perhaps through no fault of our own, we may belong to the unemployed group, so let us have a heart and strive to break down this barrier of infernal indifference.

The irony of the present situation lies in the fact that on the one hand there are hundreds of nurses willing to render service in return for a minimum living wage,

and on the other hand, hundreds are in need of skilled nursing care but unable to pay even a minimum fee for nursing service.

We believe state health insurance is near at hand, but what about the nursing service which we believe to be so important? If health insurance does come, as we feel sure it will, will it include a nursing programme, and if so how efficient will it be? The place of the nurse in any health insurance scheme should be largely determined by the organized nursing group. Shall we wait for it to take us by surprise or shall we show our initiative and organize our own group on a strictly professional basis and not be bound by political favours or disfavours? The urgent need of employment for nurses is important, but it is not as vital as the need for nursing service to all citizens, regardless of their ability to pay or their place of residence.

### *The Registries*

I fear the majority of our registries are organized merely as centres to provide employment to the small number of nurses they have enrolled, rather than to give nursing service to the community. Most of them, if not all, have no financial backing and have to depend entirely on the fees paid by the enrolled members; therefore they are in no financial position to try out any new plan. Under any new policy or type of organization, the patient should be able to secure the care required, both from the standpoint of hours and type of nursing service. The patient who, at the present time, employs a nurse for private duty has, of necessity, to employ her for the number of hours outlined as a working day by the registry of which she is a member. The patient may need the nurse for only a part of that time and yet must pay her for time when she is not really employed in nursing service.

### *Cut Rates*

Another problem is the lower rates charged by graduate nurses who are not members of registries or of any controlling organization. Many of this group have had good training, and may or may not be registered in the province, but in order to get employment they start a cut-rate nursing service. Unfortunately some of the medical profession see no reason why these nurses should not be employed and call them in preference to the nurse who has been loyally living up to the rules and regulations of her local registry, alumnae association or hospital. The nurse who charges $4.00 for twelve-hour duty works for 33 1-3 cents per hour; a charge of $5.00 for twelve hours works out at 41 2-3 cents per hour and a charge of $3.00 for eight hours to 37 1-2 cents per hour. The common labourer, the unskilled worker gets a higher wage than this, and yet some registered nurses value their services as low as eighteen cents per hour or $15.00 per week and are not only nursing the sick but are doing housekeeping, washing and cooking. All this sounds very mercenary yet it is of vital importance to the private duty nurse who is dependent entirely on her own earnings and may be forced to accept any kind of employment at any price in order to avoid going on relief. We admire their pluck but we must admit that they are making nursing an occupation rather than elevating it to a profession and certainly are not helping to raise the status of the private duty nurse.

### *Possible Modifications*

In London, we are anxious to reorganize our registry and to place a group of nurses on salary and to provide patients who cannot pay the standard fee with trained nursing service. It is our idea that this group of nurses would do eight-hour duty and would give hourly or daily nursing service as the case required. We planned calling a meeting of representatives from such groups as the Home and School Club, the I.O.D.E., Y.W.C.A., YM.C.A., the Catholic Women's League

and the insurance companies, and with the helpful suggestions of these groups to formulate some workable plan. Then came the question of finance. Should each individual who received nursing care be asked to contribute a small amount or should we start some plan of insurance whereby each family, who desired to do so, would contribute a definite amount each month and so be entitled to receive nursing care for any member of that family when sickness occurred?

Then came the problem of collecting these monthly fees, as well as the problem of advertising, which is always expensive. The difficulty of getting the public educated to new plans, not to mention educating the medical and nursing professions, seemed to be one of the greatest problems. If such a plan as this worked out well, would it interfere with the field of private duty nursing? And the greatest problem of all: who would do the organizing of such a programme? In London, for the present at least, we are forced to admit this is too big a question for one individual registry to solve.

### *Licensure*

It is quite apparent that legislation should be secured to license *all* who nurse the sick for hire. At present there is no check-up on those who call themselves nurses. Any person who takes the notion can don a white dress (a so-called uniform) and pose as a nurse and, regardless of the type of training or total lack of it, be accepted by the public as a nurse. There is a group who have had some training and because of this feel they have the right to set a fee, and they, too, are free-lance in their activities. Legislation should also control those individuals who call themselves practical nurses. Many of these women are experienced and capable and have a definite place in the community while others have no training and go about exploiting people.

Why do many people prefer to employ the so-called practical nurse rather than the registered nurse? Is there a general impression abroad that registered nurses are *not* practical? Is it because registered nurses go into homes to nurse the sick and forget that other members of the household deserve some consideration? Or is it because in many cases the need is for a housekeeper rather than a well-trained and capable nurse? Or is it purely a financial problem? These questions are worth consideration by our private duty group.

### *Conclusions*

In conclusion may I sum up the measures that, in my estimation, would aid materially in raising the status of the private duty nurse:

(1) Let us continue our study, individually and in groups, of Dr. Weir's *Survey*, for very few, if any, have yet fathomed the significance of the recommendations contained in this work.

(2) Let us exert our influence towards standardizing our schools of nursing. Your membership in your provincial association is a material aid towards such a goal and your personal influence is inestimable. As a group we can make known our feelings on such an important matter and so add another link in the chain of sentiment which eventually leads up to action. Furthermore, let us urge that special emphasis be laid upon sound preliminary teaching and practice in the household arts and sciences.

(3) Let us advise young women who are considering entering schools of nursing to choose a school connected with a large general hospital where they can obtain a well-rounded training under specially trained instructors in a well-equipped school. We should make known to them that a serious condition of overcrowding exists in the nursing profession and that only competent, well-prepared women can hope to succeed in it.

(4) Let us aim to have eight-hour duty established in all the cities in Ontario by 1937. It can be done if each one

of us firmly resolves that it shall be done. This is the problem of the private duty group and not of the medical profession or of the hospitals, therefore it is entirely up to us.

(5) Let us make it clear to the public and to hospital boards, women's auxiliaries and any other groups that have influence in governing hospital management, that a staff of graduate nurses can give better nursing service in small hospitals than student nurses and at considerably less cost.

(6) Fees charged by private duty nurses have always been a matter of local adjustment, to suit each individual community, and this should be the satisfactory way providing the charges are kept within a reasonable range. A standardized maximum and minimum wage, set by the private duty section of the provincial association might be of assistance in controlling this difficult situation.

(7) Registration of all who nurse for hire is decidedly a provincial if not a Dominion problem and we feel that the private duty group should encourage and definitely work towards such a programme.

(8) State nursing is the question of the hour and concerns the private duty group more than any other. Let us not sit back with folded hands and wait for some form of legislation to impose regulations upon us without our group having first considered the matter seriously and formulated a definite workable programme.

(9) Reorganization of registries is too big a task for individual organizations, but a definite programme of reorganization could be successfully undertaken by our provincial organizations and financial aid could be given. Let us make sure that at least some of those planning such a programme are from the private duty group as this group is most directly affected by such a change and let us see that all types of nursing service are included in the reorganization.

(10) Let us keep uppermost in our minds the vital need for nursing service to all citizens, regardless of their ability to pay or their place of residence, and look upon the employment of nurses as a secondary consideration.

[*Editor's Note*: This is the second and concluding article based on an address delivered before the private duty section of the Registered Nurses Association of Ontario, April 26, 1935.]


## A TRIED REMEDY

Heat in the treatment of disease may be said to be almost instinctive; and has been employed in some form or another since the beginning of time down to the present day, when more attention than ever is being focussed upon its therapeutic uses. Its sedative effect on sensory and motor nerves, its ability to alter the local metabolism by effecting an increase of blood and lymph supply and increasing the nutrition in the parts and the resorption of exudates, renders it an element of the widest range of application in the treatment of disease. This is manifested — often very strikingly — when heat in the form of Antiphlogistine is applied in such cases as the arthritides, chronic rheumatic conditions, sciatica, affections of the upper and lower respiratory tract, and wherever the use of heat is indicated. In angina pectoris, Antiphlogistine, which maintains its heat for a long time, has been used for its sedative and pain-relieving qualities.

# Department of Nursing Education

## THE SCHOOL OF NURSING AND THE V.O.N.

GERTRUDE M. BENNETT, Director of Nursing, Ottawa Civic Hospital.

The general topic of this symposium is the Victorian Order of Nurses, its responsibilities and relationships. My contribution to the discussion will be presented from the point of view of the director of a school of nursing. In thinking over the subject one realizes immediately that conditions differ in large centres where there are public health and social service departments, and the smaller towns where there are not. In the larger centres the public health department is responsible, or should be, for welfare work and health teaching. Where the work is not done by that department or where bedside nursing is required, it seems logical to turn to the Victorian Order because its lay personnel realizes the need and because the advice and assistance given by its trained workers are extremely valuable.

### *Inter-Relationships*

It seems reasonable to take for granted that there should be close contact between the Order and the hospitals in those centres where the Order is established and that some measures leading to this end should be put into force. For example, nurses might refer maternity cases to the hospital clinics, whether they are to be confined in hospital or in the home — unless the family physician objects. The hospital, in turn, might give a list of clinic cases to the Victorian Order nurse, who could then visit the patient in her home and check up on the way in which the patient is, or is not, carrying out the doctor's orders. She might also find out what arrangements are being made for confinement and give the patient whatever instruction she feels is necessary. The maternity cases discharged from the hospital might be reported so that the Victorian Order nurse could make post-natal visits, because patients discharged from hospital have not always the advantage of the instruction which the nurse gives to the home cases for the benefit of both the mother and the baby. Some care might also be given to patients (other than maternity) who are discharged from hospital to whom a visit of advice and encouragement might be a great help in the adjustment to home conditions after illness.

In regard to children, a follow-up of discharged patients, especially feeding cases and diabetics, would be beneficial, and visits to the homes of those admitted to hospital in order to check on home conditions which may have caused the illness, might be desirable. A difficulty arises here, however, because the Victorian Order nurse is not permitted to go into homes unless a doctor is in attendance. But if there is a need, some way should be found to meet it, possibly through the hospital clinics or the medical health officer.

### *Educational Opportunities*

May I be permitted to pay tribute to the Victorian Order for the affiliations which have been offered to a limited number of pupil nurses in our schools? The course has been very popular and much appreciated by those fortunate enough to have had the advantage of taking it. I believe this educational activity should be much extended and given more publicity.

I have made a note of some of the comments which have been made by pupils who have had this course and these I should like to pass on to you. They have found that the course has given them

A contribution to a symposium which took place at the annual meeting of the Victorian Order of Nurses for Canada on May 2, 1935.

additional knowledge, a gain in self-confidence, a realization of the necessity for economy. It has stimulated their powers of observation and their ability to improvise and has promoted a ready adaptability. Furthermore, it has given them a clear idea of just how essential it is to have a good knowledge not only of nursing procedures but also of the principles of health teaching, so that their work can be well done and the many questions asked by patients and their friends answered intelligently.

Further comments have taken the form of requests. They have suggested that more teaching of the technique and procedures of the Order should be given before the pupils are sent on the district. They have requested the school of nursing to provide more opportunity for the observation of infected throats and for demonstrations of bathing the baby as it has to be done in the home. Most significant of all, they are asking that more "public health teaching" be included in the curriculum of schools of nursing.

It is felt to-day that when possible, a trained public health nurse should be a member of the staff in schools of nursing either in the instruction department or in a supervising capacity and that she should be used as a teacher. In order to carry this out in smaller centres, it might be both possible and advisable for the Victorian Order, in co-operation with the hospitals, to arrange for a short course of lectures and demonstrations to be given by the Order.

It would also be worth while if arrangements could be made for pupils, early in their training, to attend well-baby clinics and if possible, spend a short time with the nurse on the district. An early realization of the conditions in the homes from which our patients come would mean a less mechanical care of patients in hospital wards.

### *Mutual Benefits*

This has been, I am afraid, a very one-sided presentation of mutual responsibilities and relationships. However, though it may not seem so, I believe that the hospital can do its share. The better prepared our pupils are now, the better the personnel of the Order will be in the years to come. Within the Order, we are looking for expansion of its work; would it not be well if we planned to prepare those who will one day have the work to do? The larger the groups which are served by the Victorian Order of Nurses in Canada, the greater will be the publicity given to the Order. From a hospital standpoint, we wish the Order every success and trust that co-operation and mutual understanding may increase not only its own usefulness but that of the hospitals with which it may become associated.

# Notes from the National Office

Contributed by JEAN S. WILSON, Reg. N., Executive Secretary.

The progress reports of the Provincial Associations to the summer meeting of the Executive Committee of the Canadian Nurses Association were received with interest. A summary of those reports gives the outstanding activities of the provincial units as submitted to the Executive Committee.

### *Alberta*

The Alberta Association of Registered Nurses arranged a refresher course in Edmonton, with an attendance of 140; an experiment that proved most popular was the arrangement for those enrolled to spend the last day of the course in observation in the local hospitals and clinics. A Bill respecting Health Insurance, passed at the last session of the Legislature, provides for "Nursing services as offered by nurses registered under The Registered Nurses Act."

### *British Columbia*

The Registered Nurses Association of British Columbia, in conjunction with the University of British Columbia, arranged for a refresher course which was held in July. A resolution regarding "the need for organized obstetrical training, under medical supervision, in preparation for the emergencies likely to arise in isolated districts" has been forwarded to the chairman of the Public Health Section of the Canadian Nurses Association and to the Joint Study Committee in British Columbia. This resolution was passed at the annual meeting of the R.N.A.B.C.

### *Manitoba*

An agreement for reciprocal registration has been completed between the Manitoba Association of Registered Nurses and the General Nursing Council of England and Wales. Recent revision of the Act respecting the Manitoba Association of Registered Nurses includes two new clauses; one, in reference to examinations reads as follows: "All examinations and matters pertaining thereto under this Act shall be determined and conducted by and under the direction of the council of the University of Manitoba, who shall appoint the examiners therefor"; the second refers to the control exercised by the University of Manitoba: "All matters pertaining to the recognition and affiliation of hospitals under this Act shall be determined by the council of the University of Manitoba." The constitution of the M.A.R.N. now provides for a Board of Managers consisting of a president, three vice-presidents, a recording secretary, seven members of the M.A.R.N., and the conveners of the three sections: nursing education, private duty and public health. Included in the by-laws is a new clause by which the Board of Managers is empowered to appoint an executive secretary; this officer is under the direction of the Board. The curriculum for Schools of Nursing in Manitoba has recently been discussed with the President and Registrar of the University of Manitoba by a committee from the Board. A committee has been appointed to outline the qualifications for a school of nursing advisor for the province. The application form for membership in the M.A.R.N. has been revised.

### *New Brunswick*

The executive council of the New Brunswick Association of Registered Nurses has asked the New Brunswick Hospitals Association that representatives of the two bodies meet for the purpose of discussing proposed amendments to the present Registered Nurses Act, in the interests of improved nursing standards. The executive council has submitted several recommendations for consideration by the board of examiners; among them are that registered nurses examinations be held at two points in the province and

that candidates who fail twice in supplementary examination shall be asked to rewrite the entire examination. The Association is working on a plan for the appointment of a school of nursing advisor.

### *Nova Scotia*

The Registered Nurses Association of Nova Scotia continues efforts toward obtaining the co-operation of the Halifax City Board of Health in having only registered nurses employed in two of the City Hospitals which, at present, are employing partially trained nurses; in the opinion of the R.N.A.N.S. these two institutions could be used advantageously for affiliate courses by hospitals offering general training. The Association has under consideration the appointment of a school of nursing advisor. A refresher course arranged by the Halifax Branch of the R.N.A.N.S. was so successful that, in future, a similar course will be held annually.

### *Ontario*

The Registered Nurses Association of Ontario is furthering its activities in national enrolment for emergency service, reorganization of registries, and to a study of the distribution of nursing services. Membership remains constant but there are still too many nurses registered in Ontario who are without the benefits derived from membership in the provincial association.

### *Prince Edward Island*

The Registered Nurses Association of Prince Edward Island held the annual meeting for 1935 in Charlottetown on June 11. In her address, the President made special reference to the studies being carried on by the members of the private duty section and to the development of plans for inspection of schools of nursing.

### *Quebec*

Membership in the Association of Registered Nurses of the Province of Quebec was reported to be two hundred over the same date last year. At present, one of the chief interests of the members is in the endeavour of the private duty group to widen the scope of nursing service now available in order to create and develop a type of service that shall be better suited to present day community needs.

### *Saskatchewan*

The University of Saskatchewan has approved the appointment of a school of nursing advisor by the Saskatchewan Registered Nurses Association. It is expected that the appointment will be made in September.

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## TAKING THE C.M.B.

I have just returned from London, having spent a most interesting year at the Queen Mary Maternity Home, Hampstead, a small but charming hospital belonging to the Queen. The patients are all ex-service men's wives or wives of those now in the Army or Navy. Queen Mary's Needlework Guild keeps the patients supplied with lovely things, Bermuda sends all the dresses and Prince Edward Island provides sweet little woolies. The Queen herself brought this year's gift from Prince Edward Island, beautifully done up with wheat sheaves covered in silver paper. On the Queen's birthday a trousseau comes from the Montreal branch for the first girl born on the Queen's birthday; she is called "the Mary baby" and Mary is always one of her names.

The Central Midwives Board gives a course of thirty lectures delivered by doctors appointed by the board. It is also necessary to have twenty deliveries to one's credit, fifteen of which must be in hospital and the other five

on the district in the patients' homes. A large number of ante-natal examinations must also be made. A midwife is allowed to deliver normal cases only — in any abnormal presentation a doctor must always be called in. A part of our course was taken in Hackney, in the slums of London; we stayed at a Salvation Army Home and went out from there to do our nursing and deliveries. The poverty among the patients was very great but they were jolly and happy in spite of it. Stories of such makeshifts as having to bathe a baby in the frying pan or in a tin basin with a hole in it, which we had to stop up with a bit of cloth, are literally true. Going to one's cases through a London fog, and walking along by the old canals, watching the gypsies pass in barges, are thrilling experiences.

Canadian nurses must take a year's course instead of six months unless their school has a special agreement with the Central Midwives Board or their province has arranged for reciprocity privileges in England. In hospital I was not treated as an untrained nurse but for the second six months was put on the staff and given many privileges.

Taking it all in all, taking one's C.M.B. in London is great fun even though very hard work at times, but especially nice when it includes a royal wedding and a Silver Jubilee.

MARDETTE MCMASTER
(T.G.H., 1929).

# Book Reviews

MOTHER MARIANNE OF MOLOKAI. By L. V. Jacks. Published by the Macmillans in Canada, St. Martin's House, Toronto. 198 pages and index. Price, $2.40.

This book is a highly objective study of the life and work of a remarkable woman, Mother Marianne of the Order of St. Francis. Its coldness and detachment enhance its value as a historical record; the author adheres throughout to his stated aim of relating facts as they occurred with only such comment as may be necessary for a full understanding. The facts are certainly dramatic enough in themselves. They are concerned with a woman who, at the age of forty-five, embarked upon an extraordinary adventure which was to carry her thousands of miles away from the quiet life of her religious community in Syracuse, New York, to a tropical island in the Pacific in order that she and her religious associates might care for the outcast of the centuries, the lepers. The book gives an excellent outline of the social and political conditions which, in 1873, prevailed in the Kingdom of Hawaii. A description is also given of leprosy and of the harsh and stupid treatment of the unfortunate people who suffered from it. Brief but poignant reference is made to Father Damien and an account is given of the visit made to the leper colony by Robert Louis Stevenson. To nurses the most interesting feature of this book will be the clear picture which emerges of the slow development of decency, cleanliness, and order due to the unremitting toil and sacrifice of this band of devoted women. The marked administrative ability possessed by Mother Marianne is as remarkable as her courage and tenacity. She had the usual defects of these qualities but she was a good woman and a great nurse. This book should be added to nursing libraries not only for its inspirational qualities but as interesting evidence of the progress which has taken place in the control and prevention of communicable disease.

# News Notes

News items intended for publication in the ensuing issue must reach the Journal not later than the eighth of the preceding month. In order to ensure accuracy all contributions should be typewritten and double-spaced.

## ONTARIO

### Districts 2 and 3

Brantford: Miss E. M. McKee, superintendent, Brantford General Hospital, is spending her vacation in Montreal.

Brantford: Miss Marion Cuff, Reg. N., has returned to New Kensington, Pa., following a vacation in Brantford. Miss Marjorie Mann was a recent visitor at the Brantford General Hospital.

Married: On June 3, 1935, Opal Verna Duncan (B.G.H.), to Eric Jenner.

Married: On June 17, 1935, Grace Moyer (B.G.H., 1930), to William A. Forrest.

Married: On June 29, 1935, Isabel Timanus (B.G.H., 1932), to Kenneth Cronk.

Kitchener: The graduation exercises of the School of Nursing of the Kitchener-Waterloo Hospital were held recently; the pins were presented by Mrs. M. Kaufman and the diplomas by Dr. A. V. Brown. The general proficiency prize given by the Waterloo Kitchener-Waterloo Hospital Auxiliary, was awarded to Miss Lillian Vogan; the prize for surgical technique was won by Miss Paula A. Shinn; the prize for obstetrics by Miss Margaret J. Roberts. Following the exercises a reception was held on the lawn. The class was entertained by the Alumnae Association. Those in charge were Mrs. Harry Ashcroft, Miss Irma Pfeffer, and Miss Hazel Murdock, president.

Owen Sound: The annual picnic of the Alumnae Association of the Owen Sound General and Marine Hospital was held on July 5, at the summer residence of Mrs. MacMillan, Leith, Ont. Sports were enjoyed by a large number after which dinner was served, under the convenorship of Mrs. Archie Burns.

Married: Recently, Miss Jean McLeod (O.S.G.M.H., 1931), to Mr. Ernest Hutton.

### Disitrict 4

Hamilton: On June 4, 1935, the annual reunion dinner of the Alumnae Association of St. Joseph's Hospital, in honor of the graduating class of 1935, took place. Brief addresses were given by Rev. S. J. McCowell, Rev. F. Arnold, and Miss H. Heffernan, of St. Elizabeth's Nurses, Toronto. Among those present were: Dr. W. J. Downes, Dr. and Mrs. L. Playfair, Dr. and Mrs. H. J. Sullivan, Dr. and Mrs. W. Jamieson, Dr. and Mrs. R. Fraser, Dr. F. Smith, the Misses F. Roach and H. Webster. Miss Murray, president of the Association, welcomed the guests. Toasts were given to our Sovereign Rulers, Alma Mater, and the graduating class and, after they had been responded to, a very enjoyable evening was brought to a close. Miss Teresa McAgy, of Hollywood, California, has been visiting friends.

St. Joseph's Hospital: Among the nursing sisters to receive the King's Silver Jubilee medals were: Reverend Mother Martina, superior, and Sister M. Monica, superintendent of the school of nursing.

Married: Recently, Miss H. Hubble (St. J. H., 1929), to Mr. I. White.

Married: On June 29, 1935, Miss Ailene M. McQuillan (St. J. H., 1933), to Mr. George Fletcher.

### District 5

Toronto Western Hospital: Miss Eileen Playle, assistant operating room supervisor, has accepted a position as industrial nurse at the Canadian National Carbon Co. Ltd., Toronto. Miss Flora MacLean (T.W.H., 1928), has left to be married.

Married: In July, 1935, Miss Phyllis Woodman (T.W.H., 1928), to Mr. Robert Lee.

Married: In July, 1935, Miss Kathleen MacMillan (T.W.H., 1929), to Mr. Douglas Chant.

Toronto: Riverdale Hospital: The King's Jubilee Medal was awarded to Miss Kate Mathieson, superintendent of nurses.

Married: On August 3, 1935, Edna A. Blair (Victoria Hospital, London), to Harry L. Edwards.

### District 8

Ottawa Civic Hospital: The graduation exercises of the Ottawa Civic Hospital were held June 19, when thirty-seven nurses received their diplomas. Mr. J. J. Lyons, chairman of the Hospital Board, presided. The class was addressed by Dr. George S. MacCarthy, representing the medical board, and by Miss Elizabeth Smellie, C.B.E., R.R.C. Following the exercises, tea was served.

Miss Jean Blyth has been appointed nurse in charge of the Physical Therapy Department. Miss Lillian Alkenbrack (Ottawa Civic Hospital 1930), has joined the staff of the X-ray department. Miss Elizabeth Curry (Ottawa Civic Hospital, 1925) who has been in charge of the operating room for eight years, has resigned. Her marriage to Dr. H. B. Kidd will take place shortly. Miss Martha McIntosh, who has been assistant supervisor, has been appointed supervisor in charge of the operating room.

ST. LUKE'S HOSPITAL: In honor of Miss Emily Maxwell, former superintendent of nurses of St. Luke's General Hospital, who was recently made an Officer of the Order of the British Empire, a dinner was held by the graduate nurses of the hospital. Seventy-six members were present including four of Miss Maxwell's class, all of whom have taken a prominent part in the nursing world: Miss Edith Rayside, C.B.E., R.R.C., Miss Eleanor Charleson, R.R.C., Miss Yvonne Baudry, R.R.C., and Mrs. Harris who was associated with the Tuberculosis Association in Ottawa for many years. During the evening, Miss Maxwell was presented with a silver tray from the graduates, also a silver tea caddy from Mrs. J. F. Kidd. Miss Maxwell thanked the members in a few well chosen words.

DISTRICT 10

FORT WILLIAM: The June meeting of District 10, R.N.A.O., was held on June 27. The President gave a detailed account of the Hamilton Convention, after which the guest speaker of the evening was introduced by Dr. Farrer. It is not often that we are privileged to have an out of town speaker, so it was with real appreciation that we welcomed Dr. E. L. Pope, Professor of Medicine, University of Alberta, Edmonton, who gave an interesting paper on the "Present Day Methods of Nursing Education." Mrs. G. Gould and Mrs. C. Cunningham gave two delightful vocal duets. Miss Wilson passed a vote of thanks, after which a social hour was enjoyed.

FORT WILLIAM: On June 27 a meeting of all public health nurses was held when plans were made for a conference of public health workers to be held early in September. The meeting was in charge of Miss Chivers-Wilson and Miss Gerry.

MARRIED: On June 26, 1935, Miss Doris Coffee (McKellar General Hospital, 1934), to Mr. L. Watkinson.

## SASKATCHEWAN

SASKATOON CITY HOSPITAL: MARRIED: On July 17, 1935, Miss Gladys M. Millsap (S.C.H., 1933), to Mr. A. H. Finlay.

MARRIED: On July 17, 1935, Miss Lola A. Morrison (S.C.H., 1933), to Mr. J. D. McAskill.

MARRIED: On July 11, 1935, Miss Helen J. Munro (S.C.H., 1931), to Mr. J. F. Reder.


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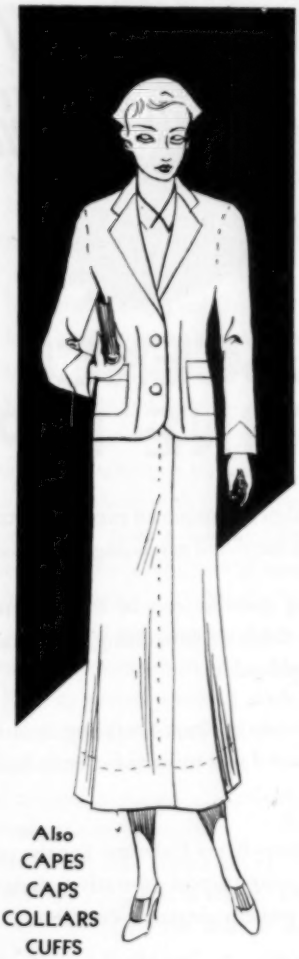

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Hon. President, Dr. H. A. Gibson; President, Miss P. Gilbert, 113 25th Ave. W.; First Vice-President, Miss F. E. C. Reid; Second Vice-President, Miss O. Zimmerman; Rec. Secretary, Miss A. Young; Corresponding Secretary, Miss M. Flemming; Treasurer, Miss M. Watt.

#### Edmonton Association of Graduate Nurses

President, Miss Ida Johnson; First Vice-President, Miss M. A. Turner; Second Vice-President, Miss E. Standing; Treasurer, Miss E. Gavin; Recording and Corresponding Secretary, Miss H. S. Peters, University Hospital, Edmonton; Registrar, Miss A. L. Sproule, 11138 Whyte Ave., Edmonton.

#### Medicine Hat Graduate Nurses Association

President, Mrs. J. Keohane; First Vice-President, Mrs. G. Crockford; Second Vice-President, Miss M. Reid; Secretary, Miss V. Crandall, Medicine Hat General Hospital; Treasurer, Miss F. Smith; *Committee Conveners: Membership*, Miss C. Walker; *Visiting*, Mrs. W. A. Fraser; *Representatives:* to *Private Duty Section*, Mrs. C. Pickering; to *The Canadian Nurse*, Miss M. Hagerman.

### BRITISH COLUMBIA

#### Nelson Graduate Nurses Association

Hon. President, Miss K. E. Gray, Superintendent Kootenay Lake General Hospital; President, Miss V. B. Eidt; First Vice-President, Miss M. Madden; Second Vice-President, Miss M. J. Leslie, Secretary-Treasurer, Miss S. K. M. Scott, Box 184, Nelson.

#### Vancouver Graduate Nurses Association

President, Miss A. Croll, 836 West 14th Ave., Vancouver; First Vice-President, Miss A. J. MacLeod, Vancouver General Hospital; Second Vice-President, Miss P. Mooney, St. Paul's Hospital; Secretary, Miss D. L. Webster, 6207 Balsam St.; Treasurer, Miss L. Archibald, 536 West 12th Ave.; *Council:* Misses K. Sanderson, M. Ewart, F. H. Walker, E. Barry, Mrs. A. G. Westman; *Committee Conveners: Finance*, Miss M. I. Teulon; *Programme*, Miss E. V. Cameron; *Membership*, Miss M. Dutton; *Visiting*, Miss J. Johnston; *Directory*, Miss M. Ogilvie; *Social*, Miss G. Currie; *Representatives:* to *the Press*, Miss G. Archibald; to *Local Council of Women*, Miss M. Gray.

#### Victoria Graduate Nurses Association

Hon. Presidents, Miss L. Mitchell, Sister Superior Ludovic; President, Miss E. Toynbee; First Vice-

President, Miss M. Mirfield; Second Vice-President, Mrs. Kirkness; Secretary, Miss M. King, 514 Ellice St.; Treasurer, Miss W. Cooke; Registrar, Miss E. Franks, 1035 Fairfield Road; *Executive Committee*, Misses T. Locke, E. McDonald, E. Cameron, D. Frampton, Mrs. E. B. Strachan.

## MANITOBA

### Brandon Graduate Nurses Association

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## ONTARIO

### Smiths Falls Graduate Nurses Association

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## QUEBEC

### Montreal Graduate Nurses Association

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## SASKATCHEWAN

### Moose Jaw Graduate Nurses Association

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# Alumnae Associations

## ALBERTA

### A.A., Royal Alexandra Hospital, Edmonton

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## BRITISH COLUMBIA

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### A.A., Royal Jubilee Hospital, Victoria

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## MANITOBA

### A.A., Children's Hospital, Winnipeg

Hon. President, Miss M. B. Allan; President, Miss Alice McAuley; First Vice-President, Miss Elsie Fraser; Secretary, Miss W. M. Barratt, Children's Hospital; Treasurer, Miss F. McLeod; *Committee Conveners: Visiting*, Miss Ditchfield; *Entertainment*, Mrs. Geo. Wilson.

### A.A., St. Boniface Hospital, St. Boniface

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### A.A., Winnipeg General Hospital, Winnipeg

Honorary President, Mrs. A. W. Moody; President, Mrs. J. W. Briggs, 70 Kingsway; First Vice-President, Miss Pearl Brownell; Second Vice-President, Mrs. J. W. Stewart; Third Vice-President, Miss M. Wilkins; Recording Secretary, Miss Anne Effler, Ste. 12, Diana Court; Corresponding Secretary, Miss Helen Ross, Winnipeg General Hospital; *Representative on Training School Committee*, Miss K. McLearn, Shriners' Hospital; *Committee Conveners: Membership*, Miss Mary Shepherd, King George Hospital; *Visiting*, Miss Grace McKeevor, Winnipeg General Hospital; *Entertainment*, Mrs. C. B. Stewart, Ste. 38, Rita Apts.; *Alumnae Club*, Miss S. Tretiak, Winnipeg General Hospital; Editor of Journal, Miss Julia Moody, 76 Walnut St.; Assistant Editor, Miss Annie Taylor, Winnipeg Gen-

eral Hospital; Business Manager, Miss E. Timlick, Winnipeg General Hospital; Archivist, Miss S. J. Pollexfen, 954 Palmerston Ave.

## NEW BRUNSWICK

### A.A., Saint John General Hospital, Saint John

Hon. President, Miss E. J. Mitchell; President, Mrs. G. L. Dunlop; First Vice-President, Miss Ethel Henderson; Second Vice-President, Mrs. F. McKelvey; Secretary, Mrs. J. Edgar Beyea, 121 Union St.; Treasurer, Miss Kate Holt; *Executive Committee:* Miss Margaret Murdoch, Miss R. Reid, Mrs. J. H. Vaughan.

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### A.A., Glace Bay General Hospital, Glace Bay

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## ONTARIO

### A.A., Belleville General Hospital, Belleville

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### A.A., Kingston General Hospital, Kingston

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### A.A., Ross Memorial Hospital, Lindsay

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**A.A., St. Joseph's Hospital, London**

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**A.A., Victoria Hospital, London**

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**A.A., Niagara Falls General Hospital, Niagara Falls**

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**A.A., Orillia Soldiers' Memorial Hospital, Orillia**

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**A.A., Oshawa General Hospital, Oshawa**

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**A.A., Lady Stanley Institute (Incorporated 1918), Ottawa**

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**A.A., Ottawa Civic Hospital, Ottawa**

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**A.A., Ottawa General Hospital, Ottawa**

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**A.A., St. Luke's Hospital, Ottawa**

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**A.A., Owen Sound General and Marine Hospital, Owen Sound**

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**A.A., Sarnia General Hospital, Sarnia**

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**A.A., Chambers Memorial Hospital, Smiths Falls**

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**A.A., Stratford General Hospital, Stratford**

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**A.A., Memorial Hospital, St. Thomas**

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**A.A., Grace Division, Toronto Western Hospital Toronto**

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### A.A., Hospital for Sick Children, Toronto

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### A.A., Riverdale Hospital, Toronto

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### A.A., School of Nursing, University of Toronto, Toronto

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